STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		Ti i i i i i i i i i i i i i i i i i i		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155254	B. WING		07/12/2011
NAME OF P	PROVIDER OR SUPPLIE	D	STREET A	ADDRESS, CITY, STATE, ZIP CODE	ļ.
			1	/EST U.S. 40	
SUGAR (	SUGAR CREEK REHABILITATION CONVALESCENT CENTER		R GREEN	IFIELD, IN46140	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0000					
	This visit was fo	or a Doct Curvoy Dovicit	F0000	This plan of correction is t	
		or a Post Survey Revisit	10000	serve as Sugar Creek	<b>"</b>
	` ′	restigation of Complaint		Rehabilitation Convalesce	nt
	11100091349 001	mpleted on 6/15/11.		Center's credible allegation	n of
	This wisit was in	a conjugation with a DCD		compliance.	
		a conjunction with a PSR ation and State Licensure		Submission of this plan of	
				correction does not consti	I
	completed on 5/	12/11.		an admission by Sugar Cre	** **
	G 1: DIO	2001040		Rehabilitation Convalesce	
	Complaint IN00	091349 - not corrected.		Center or it's management	
				company that the allegatio	
	Survey dates: Ju	uly 11 and 12, 2011		contained in the survey re	port
				portrayal of the provision of	of
	Facility number:			nursing care and other	"
	Provider number			services in this facility. No	or
	AIM number: 1	00274720		does this submission	
				constitute an agreement of	r
	Survey team:			admission of the survey	
	Barbara Gray R	N		allegations.	
	Census bed type	»:			
	SNF/NF: 48				
	Total: 48				
	Census payor ty	pe:			
	Medicare: 6				
	Medicaid: 31				
	Other: 11				
	Total: 48				
	Sample: 4				
	These deficienci	ies reflect state findings			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

KU4U12

Facility ID:

000157

TITLE

(X6) DATE

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

l		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155254	A. BUILI	DING	NSTRUCTION 00	(X3) DATE ( COMPL <b>07/12/2</b>	ETED
133234			B. WING		DDDEGG GITTU GTATE GID GODE	07/12/2	011
NAME OF P	ROVIDER OR SUPPLIER				NDDRESS, CITY, STATE, ZIP CODE EST U.S. 40		
		ATION CONVALESCENT CENTER		GREEN	IFIELD, IN46140		
(X4) ID		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG			1	REFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΤE	COMPLETION DATE
TAG	cited in accordan	ice with 410 IAC 16.2.  completed 7/14/11 by N.		TAG	DEFICIENCY		DATE

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	00	COMPL	ETED
		155254	B. WING	1110		07/12/2	011
				STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				EST U.S. 40		
SUGAR	CREEK REHABILIT	ATION CONVALESCENT CENTE			FIELD, IN46140		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PI	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
F0225	,	ot employ individuals who					
SS=D		guilty of abusing, neglecting,					
		dents by a court of law; or					
		entered into the State					
		/ concerning abuse, neglect, sidents or misappropriation					
		and report any knowledge it					
		a court of law against an					
		would indicate unfitness for					
		aide or other facility staff to					
	the State nurse aid	de registry or licensing					
	authorities.						
		nsure that all alleged					
	3	g mistreatment, neglect, or					
		njuries of unknown source					
		ion of resident property are rely to the administrator of					
		other officials in accordance					
		ough established procedures					
		tate survey and certification					
	agency).						
	,	ave evidence that all					
		are thoroughly investigated,					
		further potential abuse while					
	the investigation is	s in progress.					
	The results of all is	nvestigations must be					
		ministrator or his designated					
		d to other officials in					
	·	State law (including to the					
		certification agency) within 5					
		e incident, and if the alleged					
		appropriate corrective					
	action must be tak						,
	Based on intervie	ew and record review, the	F022	25			07/22/2011
	facility failed to	thoroughly investigate an			F225 483.13(c)(1)(ii)-(iii), (c)		
	injury of unknow	on source that resulted in			(4) INVESTIGATE/REPORT		
		re for 1 of 1 resident			ALLEGATIONS/INDIVIDUAL	.ა	
		eture, in a sample of 4.			It is the practice of Sugar Cre	ek	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE : COMPL		
AND PLAN	OF CORRECTION	155254	A. BUII	LDING	00	07/12/2	
		133234	B. WIN			07/12/2	011
NAME OF	PROVIDER OR SUPPLIE	8		1	DDRESS, CITY, STATE, ZIP CODE EST U.S. 40		
SUGAR	CREEK REHABII IT	TATION CONVALESCENT CENTE	:R	1	EST 0.5. 40 FIELD, IN46140		
				<u> </u>			(7/5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
	(Resident #D)				Rehabilitation Convalescent		
	(Resident #B)				Center to ensure that all alleg	ged	
	Findings include				violations involving mistreatn	nent,	
	Tillianigs include	·-			neglect, or abuse, including	nd	
	Resident #D's re	cord was reviewed on			injuries of unknown source a misappropriation of resident	na	
		P.M. Diagnoses included,			property are reported immed	iately	
		ited to, advanced			to the administrator of the fac	cility	
		porosis, cerebral vascular			and to other officials in		
		with left hemiplegia,			accordance with state law through established procedu	res	
	` ′	d leg contractures, and			including to the state survey		
	seizure disorder.				certification agency.		
	seizure disorder.						
	A assautants Mini	maxim Data Sat			<ul> <li>I. The incident involving Resi</li> <li>D has been investigated to the</li> </ul>		
	A quarterly Mini				degree it is possible at this ti		
		Resident #D, dated 4/8/11,					
		s rarely understood and			II. All residents have the pote		
	1 *	d others, her cognitive			to be affected. This has bee	n	
	1	ecision making were			addressed by the systems described below.		
		d, she was totally			accombat bolow.		
	_	e person for bed mobility,			III. The facility policy regarding	ng	
	1	al hygiene, and toileting,			Abuse Prevention has been		
	1	ependent on two persons			reviewed and amended. New reporting and investigation to		
	for transfer, and	she did not walk.			have been implemented to a		
		d D 11 (UD) C 11			personnel in obtaining impro-	ved	
		th Resident #D's family			documentation of interviews	and	
		3 P.M., indicated he			the conclusion of the investigation. In addition, the	<u>.</u>	
		nt #D fractured her right			Administrator is reviewing the		
	1 -	Resident #D's family			investigation and confidentia		
		nt #D began moaning			statements and signing the fi	inal	
	1	care that day. Resident			summary of findings. This		
	#D's family indicated the fracture could				confidential file is being maintained in the Administration	tor's	
		hen or the fracture could			office. Facility personnel hav		
	have happened earlier in the day, he just				been educated on this new		
		sident #D's family			process.		
	indicated Reside	nt #D had brittle bones					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155254 07/12/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5430 WEST U.S. 40 SUGAR CREEK REHABILITATION CONVALESCENT CENTER GREENFIELD, IN46140 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE that could fracture easily. Resident #D's IV. The Administrator or her designee is completing quality family indicated Resident #D fractured improvement audits of all resident her left leg a couple years previously, just abuse allegations including by a family member lifting her leg. incidents of unusual occurrence. Although the individual resident issues will be held confidential, An initial with follow up Facility Incident the results of the audits will be Reporting documentation provided by the discussed during the facility's Administrator on 7/11/11 at 3:00 P.M., quality assurance meeting indicated the following: Brief description monthly. of incident - CNA reported to writer when residents husband was putting bilateral lower multi-podus boots on resident, he elevated her leg and when doing so, resident moaned and grimaced. Type of injury - right hip fracture. Immediate action taken - Dr. and family notified. X-ray ordered and revealed right hip fracture. Preventive measures taken - bed rest times 2 weeks, all splints and multi-podus boots discontinued secondary to risks outweigh benefits, pain medicine ordered, resident evaluated for Hospice and picked up on caseload. An interview with the Administrator on 7/12/11 at 11:47 A.M., indicated she put the Assistant Director of Nursing (ADON) in charge of the investigation. The ADON interviewed staff members but the Administrator could not provide the investigation for review, indicating she was unable to locate the investigation. The ADON spoke with Resident #D's daughter about the fracture but did not

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

KU4U12

Facility ID: 000157

If continuation sheet

Page 5 of 16

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO	nstruction 00	(X3) DATE : COMPL 07/12/2	ETED	
		155254	B. WIN		DDDEGG OWN GTATE ZID CODE	07/12/2	011
NAME OF I	PROVIDER OR SUPPLIE	R		1	DDRESS, CITY, STATE, ZIP CODE EST U.S. 40		
SUGAR	CREEK REHABILIT	TATION CONVALESCENT CENTE	R		FIELD, IN46140		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	, i	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION DATE
1110		ent #D's husband. There	+	ino			DATE
		s and the results of the					
	·	ere not documented on the					
	~	Reporting form follow					
	I -	receive the completed					
	investigation fro	-					
	Staff interviews	were provided by the					
		n 7/12/11 at 11:45 A.M.,					
	which she indica	ated were e-mailed to her					
	from the ADON	who was out of town the					
	evening of 7/11/	11. The Administrator					
	indicated she ha	d the staff who were					
	interviewed, sign	n the e-mailed interviews,					
	the morning of 7	7/12/11. 3 of the					
		signed, with no time or					
		d as to when they were					
	1 -	ministrator indicated the					
		nterview would be signed					
	*	en she reported to work					
	_	/12/11. The interviews					
	indicated the fol	lowing:					
	1.) (No date or	time of interview					
	· ` `	his writer questioned					
	CNA #1 in regai	rds to Resident #D. CNA					
	1	l not have Resident #D on					
	her assignment t	the night of 6/28/11.					
	CNA#1 stated s	he did have contact with					
	Resident #D but	never noted any distress					
	or signs of pain.	Resident #D acted and					
	looked the same	way she always did,					
	nothing seemed	different with her.					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			LDING	NSTRUCTION  00	(X3) DATE S COMPL 07/12/2	ETED	
NAME OF I	PROVIDER OR SUPPLIEI	<b>!!</b> ?	P: 112	STREET A	DDRESS, CITY, STATE, ZIP CODE	<u> </u>	
SUGAR	CREEK REHABILIT	TATION CONVALESCENT CENT	ER	1	FIELD, IN46140		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	documented.) T CNA #2 about p bed. CNA #2 sta Resident #D to b anything different writer asked if R groaned or displ when putting her responded Resid anything out of to indicated she putthe Hoyer lift the did with the help #2 indicated she nurse if she thou with Resident #I  3.) (No date or to documented.) T Resident #D's ro was in the middl and reported Resident reported both of usually pulled up looked like it wat CNA #3 reported top half of Resident yet moved her  4.) (No date or to documented.) C	thent #D did not do the ordinary. CNA #2 t Resident #D to bed with the same way she always to of another CNA. CNA would have notified the tight anything was wrong time of interview this writer was called to toom by CNA #3. CNA #3 the of performing ADL's tight and usual. CNA #3 Resident #D's right leg t than usual. CNA #3 Resident #D's legs were to tight but her right leg tals loose or something. The shed only washed the tight body and had					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155254		(X2) MULTIPLE A. BUILDING B. WING	00	lì í	TE SURVEY  IPLETED  1/2011			
	PROVIDER OR SUPPLIER	I ATION CONVALESCENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  5430 WEST U.S. 40  ER GREENFIELD, IN46140					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
	completed Resident transferred her to use of a Hoyer life said she was clear saw a family mer #D's splint-boot of Resident #D's riggroaned. CNA # never made any facial grimacing having any pain.  No further document investigation was This federal tag in IN00091349.  This deficiency of facility failed to interest the said of the said transfer in the said transfer i	the wheelchair with the ft successfully. CNA #4 uning up her mess and mber putting Resident on her right leg. When the leg was lifted she 4 reported Resident #D further moans and had no or acted like she was						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155254 07/12/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5430 WEST U.S. 40 SUGAR CREEK REHABILITATION CONVALESCENT CENTER GREENFIELD, IN46140 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE The facility must develop and implement F0226 written policies and procedures that prohibit SS=D mistreatment, neglect, and abuse of residents and misappropriation of resident property. F0226 F226 483.13(c) 07/22/2011 Based on interview and record review, the **DEVELOP/IMPLEMENT** facility failed to follow the policy to **ABUSE/NEGLECT POLICIES It** thoroughly investigate an injury of is the practice of Sugar Creek unknown source that resulted in a right Rehabilitation Convalescent hip fracture for 1 of 1 resident reviewed Center to develop and implement policies and procedures that for fracture, in a sample of 4. (Resident prohibit mistreatment, neglect, #D) and abuse of residents and misappropriation of property.I. Findings include: The incident involving Resident D has been investigated to the degree it is possible at this time. Resident #D's record was reviewed on II. All residents have the potential 7/11/11 at 3:45 P.M. Diagnoses included to be affected. This has been but were not limited to advanced addressed by the systems described below. III. The facility dementia, osteoporosis, cerebral vascular policy regarding Abuse accident (stroke) with left hemiplegia, Prevention has been reviewed bilateral hand and leg contractures, and and amended. New reporting seizure disorder. and investigation tools have been implemented to assist personnel in obtaining improved A quarterly Minimum Data Set documentation of interviews and assessment for Resident #D, dated 4/8/11, the conclusion of the indicated she rarely understood and rarely investigation. In addition, the Administrator is reviewing the understood others, her cognitive skills for investigation and confidential daily decision making were severely statements and signing the final impaired, she was totally dependent on 1 summary of findings. This person for bed mobility, dressing, confidential file is being personal hygiene, and toileting, she was maintained in the Administrator's office. Facility personnel have totally dependent on 2 persons for been educated on this new transfer, and she did not walk. process. IV. The Administrator or

000157

STATEMEN	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED	
		155254	B. WIN			07/12/20	011	
			<u> </u>		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIER			5430 W	'EST U.S. 40			
	CREEK REHABILIT	ATION CONVALESCENT CENTER	₹		IFIELD, IN46140			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ГЕ	COMPLETION	
IAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<del> </del>	IAG		u olitu	DATE	
TAG	An interview wit on 7/11/11 at 3:3 believed Residen hip on 6/28/11. I indicated Resider while receiving of #D's family indicated have happened the have happened endidn't know. Resident that could fractur family indicated her left leg a courby a family mem.  An initial with for Reporting docum. Administrator on indicated the folloof incident - CNA residents husband lower multi-poducelevated her leg a resident moaned injury - right hip action taken - Dr. X-ray ordered an	th Resident #D's family 3 P.M., indicated he at #D fractured her right Resident #D's family are that day. Resident cated the fracture could arlier in the day, he just ident #D's family are that brittle bones are easily. Resident #D's Resident #D fractured ple years previously, just ber lifting her leg.  bllow up Facility Incident mentation provided by the a 7/11/11 at 3:00 P.M., owing: Brief description A reported to writer when d was putting bilateral as boots on resident, he and when doing so, and grimaced. Type of fracture. Immediate and family notified. d revealed right hip tive measures taken - bed as, all splints and		TAG	her designee is completing of improvement audits of all rest abuse allegations including incidents of unusual occurrer. Although the individual residissues will be held confident the results of the audits will be discussed during the facility's quality assurance meeting monthly.	juality sident nce. ent al,	DATE	
	multi-podus boots discontinued secondary							
	-	benefits, pain medicine						
	_	evaluated for Hospice						
	zautru, resident							

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X1) PROVIDER/SUPPLIER		(X2) M	IULTIPLE CO	NSTRUCTION 00	li i	TE SURVEY MPLETED	
THID I LITTLE	or conduction	155254	_ I	LDING	<del></del>		2/2011
			B. WIN		DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				EST U.S. 40	,	
SUGAR	CREEK REHABILIT	ATION CONVALESCENT CENT	ΞR	•	FIELD, IN46140		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORREC	TION	(X5)
PREFIX	, i	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	.D BE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	and picked up on	caseload.					
		h the Administrator on					
		A.M., indicated she put					
		ector of Nursing (ADON)					
	"	nvestigation. The ADON members but the					
		ald not provide the review, indicating she					
		cate the investigation.					
		e with Resident #D's					
	_	ne fracture but did not					
	"	nt #D's husband. There					
		and the results of the					
	·	re not documented on the					
		Reporting form follow					
		receive the completed					
	investigation from	_					
	in very gavien ner	w. v. 125 01 (.					
	Staff interviews	were provided by the					
		7/12/11 at 11:45 A.M.,					
	which she indica	ted were e-mailed to her					
	from the ADON	who was out of town the					
	evening of 7/11/1	11. The Administrator					
	indicated she had	I the staff who were					
	interviewed, sign	the e-mailed interviews,					
	the morning of 7	/12/11. Three of the					
	interviews were	signed, with no time or					
	date documented	as to when they were					
	-	ninistrator indicated the					
		terview would be signed					
	l -	n she reported to work					
	1	12/11. The interviews					
	indicated the foll	owing:					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:  155254			ILDING	NSTRUCTION  00	COM	E SURVEY PLETED 7/2011	
	PROVIDER OR SUPPLIER	TATION CONVALESCENT CENT	ER	5430 W	DDRESS, CITY, STATE, ZIP COI EST U.S. 40 FIELD, IN46140	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHG CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	documented.) T CNA #1 in regar #1 stated she did her assignment t CNA #1 stated s Resident #D but or signs of pain. looked the same nothing seemed  2.) (No date or t documented.) T CNA #2 about p bed. CNA #2 sta Resident #D to t anything differen writer asked if R groaned or displa when putting her responded Resid anything out of t indicated she put the Hoyer lift the did with the help #2 indicated she nurse if she thou with Resident #I  3.) (No date or t documented.) T Resident #D's ro	ent #D did not do he ordinary. CNA #2 t Resident #D to bed with e same way she always of another CNA. CNA would have notified the ght anything was wrong					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE COMPL		
AND PLAN	OF CORRECTION	155254	- 1	LDING	00	07/12/2	
		100201	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	0171272	
NAME OF I	PROVIDER OR SUPPLIER			1	EST U.S. 40		
SUGAR	CREEK REHABILITA	ATION CONVALESCENT CENT	ER	1	IFIELD, IN46140		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ident #D's right leg					
		than usual". CNA #3					
	1 ^	Resident #D's legs were					
		tight but her right leg					
		s loose or something.					
	_	she had only washed the					
	_	ent #D's body and had					
	not yet moved he	ΣΓ.					
	4.) (No date or ti	ime of interview					
	1 ' '	NA #4 reported to this					
	l '	etting Resident #D out of					
		CNA #4 stated she					
	completed Reside						
	_	the wheelchair with the					
		ft successfully. CNA #4					
	*	ning up her mess and					
		nber putting Resident					
		on her right leg. When					
	_	tht leg was lifted she					
	<u> </u>	4 reported Resident #D					
	-	further moans and had no					
		or acted like she was					
	having any pain.						
	,						
	No further docum	nentation related to the					
	investigation was	s provided.					
		abuse policy and					
		ed by the Administrator					
		00 A.M., indicated the					
		y statement - All reports					
		, neglect and injuries of					
	unknown source	shall be promptly and					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

KU4U12 Facility ID:

000157

If continuation sheet

Page 13 of 16

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUI	ILDING	NSTRUCTION  00	(X3) DATE SURVEY COMPLETED 07/12/2011		
			B. WIN		DDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEI	₹		1	EST U.S. 40		
SUGAR	CREEK REHABILIT	TATION CONVALESCENT CENTI	ER	GREEN	FIELD, IN46140		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	· ·	NCY MUST BE PERCEDED BY FULL  LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION DATE
IAG		stigated by facility		IAG			DATE
	1 2	olicy interpretation and					
	1	- 1.) Should an incident					
		ident of resident abuse,					
	_	of an unknown source be					
	1	ministrator, or his/her					
	1 *	opoint a member of					
	1	investigate the alleged					
	_	e Administrator will					
	· · · · · · · · · · · · · · · · · · ·	erson in charge of the					
	1 ^	ompleted copy of the					
	1	n, witness statement,					
	1	on regarding the alleged					
	incident. 3.) Th	ne individual conducting					
	the investigation	will, at a minimum: a.)					
	Review the resid	lent's medical record to					
	determine events	s leading up to the					
	incident.; b.) In	terview the person(s)					
	reporting the inc	ident; c.) Interview any					
	witnesses to the	incident; d.) Interview					
	the resident (as a	nedically appropriate);					
	e.) Interview the	e resident's attending					
	physician to dete	ermine the resident's					
	current mental s	tatus; f.) Interview staff					
	,	shifts) who have had					
		resident during the period					
	_	cident; g.) Interview the					
		nate, family members, and					
		erview other residents to					
		ed employee provides					
		and i.) Review all					
	events leading up to the alleged incident						
	· /	ng guidelines will be used					
	when conducting	g interviews: a.) Each					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

KU4U12 Facility ID:

000157

If continuation sheet

Page 14 of 16

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155254	A. BUII	LDING	NSTRUCTION 00	(X3) DATE COMPI 07/12/2	ETED		
NAME OF PROVIDER OR SUPPLIER  SUGAR CREEK REHABILITATION CONVALESCENT CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE  5430 WEST U.S. 40					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	and in a private I and confidentiall explained thorou involved in the in Witness reports writing. Witness sign and date such individual in chan will consult with daily basis concerprogress/findings. The Administrate and his/her represent informed of the prinvestigation. It investigation will copy of the complete provided to the working days of 12.) The Administrated and his/lessed to the working days of 12.) The Administrated and his/lessed to the working days of 13. The Administration and within 5 days of investigation and within 5 days of investigation"  This federal tag is IN00091349.	s of the investigation. 9.) or will keep the resident sentative (sponsor) orogress of the 0.) The results of the I be documented. 11.) A oleted investigation will e Administrator within 5 the reported incident. istrator will inform the ner representative							

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFI		IXI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155254	A. BUILDING  B. WING		COMP	COMPLETED 07/12/2011		
	PROVIDER OR SUPPLIER	II S SATION CONVALESCENT CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE 5430 WEST U.S. 40					
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL PR REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  COMPLETION DATE				
	3.1-28(a)		TAG					